REQUEST FOR MEDICAL INFORMATION FROM SOURCE OUTSIDE THE NATIONAL INSTITUTES OF HEALTH

INSTRUCTIONS: Complete this form in its entirety. Remove the last copy and retain for your records. Forward the remainder of the form set to the Medical Records Department, Medicolegal Section, Building 10, Room 1N216 (496-3331). ALL REQUESTS MUST REFERENCE FORMALLY REGISTERED PATIENTS OF THE WARREN GRANT MAGNUSON CLINICAL CENTER (CC).

SOURCE OF INFORMATION REQUESTED

(Name of Health Care Organization or Physician)

(Street Address) (City) (State) (Zip Code)

CC PATIENT IDENTIFICATION

(Patient Name) (Patient Number) (Date of Birth)

When requesting MILITARY RECORDS, please furnish:

(Sponsor Name) (Sponsor Social Security Number)

INFORMATION REQUESTED

Identify the specific items and related dates pertaining to the information to be released.

1. Medical Reports

Send to: National Institutes of Health
Warren Grant Magnuson Clinical Center
(Name of Department)
Building 10, Room (Room Number)
10 CENTER DRIVE MSC (Mail Stop Code)
BETHESDA, MD 20892- (Mail Stop Code)
ATTENTION: (Name of Requesting Physician)

2. X-Ray Films and X-ray Reports

Send to: National Institutes of Health
Warren Grant Magnuson Clinical Center
Diagnostic Radiology Department
Building 10, Room 1C660
10 CENTER DRIVE MSC 1516
BETHESDA, MD 20892-1516

3. Pathological Slides

Send to: National Institutes of Health
Warren Grant Magnuson Clinical Center
Pathological Anatomy Department
Building 10, Room 2N212
10 CENTER DRIVE MSC 1182
BETHESDA, MD 20892-1182

AUTHORIZATION

I hereby authorize the release of the above-requested medical information.

(Signature of Patient/Legal Guardian) (Printed Name of Patient) (Date Signed)

(Street Address) (City) (State) (Zip Code)

General

This statement is provided to the Privacy Act of 1974 (P.L. 93-579). Information collected will be incorporated into the system of records 09-25-0099.
Clinical Research: Patient Medical Records, HEW/NIH/CC. (Refer to DHEW, Annual Republication of Notices of System of Records found in the Federal Register)

Authority for Collection of Information

Public Health Service Act, (42 U.S.C. 241, 248)

Principal Purposes and Routine Uses

A complete medical history is required for your participation in the research conducted at the National Institutes of Health. To obtain a complete medical history, w e must contact physicians and/or health care facilities that have provided you with care in the past. When this form is completed, it authorizes health care providers to release medical information to NIH.

All military facilities maintain their medical information by social security number. Release of medical information maintained by a military facility requires an authorization and the sponsor's name and social security number.

Effects of Nondisclosure

Completion of this form is mandatory to obtain requested medical information. Failure to provide the information requested (including sponsor's name and social security number for military personnel/dependents) may result in cancellation of your Clinical Center admission.

*U.S. GPO: 1997-429-962/60143